Bureau of Health Care Quality & Compliance

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		NVS3184AGC		B. WING	<del></del>	03/3	0/2009
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		<u> </u>
MARGARI	ET ROSE RED ROCK AS	STD LIV	5975 W TW LAS VEGA	/AIN AVE S, NV 89103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
Y 000	Initial Comments			Y 000			
	by the Health Division prohibiting any crimin actions or other claim available to any party state, or local laws.  This Statement of De a result of an annual conducted in your fac completed on 3/30/0s survey was conducted 449.150, Powers of the facility is licensed for Group beds for eleand/or persons with recategory I, 5 beds Cathe time of the survey files were reviewed a reviewed. One discharge in the following deficier of the survey files were reviewed.  The following deficier	9. This State Licensure of by the authority of NF he Health Division.  d for 83 Residential Factority and disabled persmental illness, 78 beds ategory II. The census y was 66. Fifteen resident 11 employee files was arged resident file was notices were identified:	d as d as d as ral, ed as description at ent				
Y 053 SS=D	449.194(4) Administr Responsibilities-Com			Y 053			
		a residential facility sha cords of the facility are te.	ili:				
	This Regulation is no	ot met as evidenced by:	·				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 07/09/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3184AGC 03/30/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5975 W TWAIN AVE MARGARET ROSE RED ROCK ASSTD LIV LAS VEGAS, NV 89103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 053 Y 053 Continued From page 1 Based on observation, interview and record review 3/24-30/09, the administrator failed to enusure the medication administration records for 1 of 15 residents were accurate. Findings include: Resident #10 - The resident's medication administration records (MAR) for January, February and March 2009, revealed the resident was prescribed Hydrochlorothiazide (HCTZ) 25 mg, 1/2 tablet daily for blood pressure. Doctor's orders in the resident's file showed the medication was initially ordered on 11/24/08 but there was also an order from the physician dated 2/11/09 to discontinue use of the medication. Review of the February and March 2009 MARs revealed the medication technicians continued to document giving the resident the HCTZ from 2/12/09 through the day of the survey on 3/24/09. There were no HCTZ containers in with the resident's medications. The medication technicians could not determine if the medication had been given after it was discontinued, when the medication ran out or if it was just being documented as given out of habit. Further review of Resident #10's MARs determined the resident was prescribed Hydrocodone with APAP 5/500 mg, two times a day. The medication order was initiated on 11/24/08 but this medication was discontinued by the resident's physician on 2/19/09. Medication technicians continued to document giving the

resident the Hydrocodone twice daily from 2/20/09 through the day of the survey on 3/24/09. There were no containers of Hydrocodone/ APAP with the resident's medications. The medication technicians could not determine if the medication had been given after it was discontinued, when

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NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
MARGARI	ET ROSE RED ROCK AS	STD LIV	5975 W TW LAS VEGAS	AIN AVE S, NV 89103			
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Y 053	Continued From page	2		Y 053			
	the medication ran ou documented as given	ut or if it was just being out of habit.					
	Severity: 2 Scope: 1						
Y 070 SS=F	449.196(1)(f) Qualific training	ations of Caregiver-8 h	ours	Y 070			
	NAC 449.196 1. A caregiver of a restacility must: (f) Receive annually rhours of training relatfor the needs of the residential facility.	not less than 8 ed to providing					
	Based on record reviethe facility failed provious caregivers completed documented by the fath 44, #5 and #6) and fath competency of self-st	ot met as evidenced by: ew and interview on 3/2 ide evidence that 5 of 1 self-study training as acility (Employees #1, # illed to review employe udy training for 5 of 10 e #3, #7, #8, #10 and #	24/09, 0 22, e				
	Severity: 2 Scope: 3						
Y 103 SS=F	449.200(1)(d) Person	nel File - NAC 441A		Y 103			
	a separate personnel member of the staff o	e provided in subsection file must be kept for east far facility and must income ates required pursuant for the employee.	ach lude:				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SU COMPLET	
		NVS3184AGC		B. WING	·	03/3	0/2009
	OVIDER OR SUPPLIER	•	5975 W TW	RESS, CITY, STA VAIN AVE S, NV 89103	TE, ZIP CODE	, 00.0	<del>3.2333</del>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
Y 103	Continued From page	e 3		Y 103			
Y 105 SS=E	Based on record revifailed to ensure that a pre-employment physis, #7, #8, #9, #10 and # evidence of a positive chest x-rays (Employhad TB signs and syn #1, #2, #3 and #5) a evidence of an annua (Employee #11).  Severity: 2 Scope:		ility a , #5, had their es oyees ad	Y 105			
30-1	a separate personne member of the staff of (f) Evidence of comp 449.185, inclusive.	se provided in subsecti I file must be kept for e of a facility and must in liance with NRS 449.1	ach clude: 76 to				
	failed to ensure 3 of	iew on 3/24/09, the faci 11 employees met equirements (Employee	·				
	Severity: 2 Scope:	2					
Y 106 SS=D	449.200(2)(a) Persor	nnel File - 1st aid & CP	R	Y 106			
	NAC 449.200 2. The personnel file	for a caregiver of a					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB		A. BUILDING	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		NVS3184AGC		B. WING		03/3	0/2009
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	-	
MARGARI	ET ROSE RED ROCK AS	STD LIV	5975 W TW LAS VEGAS	AIN AVE S, NV 89103			
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Y 106	Continued From page	e 4		Y 106			
	information required p						
	Based on interview at the facility failed to er	ot met as evidenced by: nd record review on 3/2 nsure 2 of 10 caregivers first aid (Employee #3	24/09, s had				
Y 255 SS=F	449.217(6)(a)(b) Perr	mits - Comply with NAC	446	Y 255			
	chapter 446 of NAC. (b) Obtain the necess of Health Protection S	tandards prescribed in sary permits from the B Services of the Division					
		ot met as evidenced by: n and interview on 3/24					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
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Y 255	Continued From page	e 5		Y 255			
Y 280 SS=F	label three spray bott used a non-commerc did not have an adeq solution in the wiping in the bread crumb co	n lunch (chicken); did not les of cleaning products ial microwave in the kit uate level of sanitizing cloth buckets; left a scontainer; and stored caseserve cups on the floorea.	s; chen; oop ses	Y 280			
	NAC 449.2175 10. The person provio subsection 9 shall prothan once each calent administrator of the farecord of the consultations mu (a) The development menus. (b) Training for the enkitchen. (c) Advice regarding on utritional program of (d) Any observations services regarding the meals in the facility to	acility shall keep a writtentions on file at the facilist include: and review of weekly anployees who work in the	t less en ity. he the ce of is in				

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

NVS3184AGC

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

03/30/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PR	OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MARGARI	ET ROSE RED ROCK ASSTD LIV	5975 W TW LAS VEGAS			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 280	Continued From page 6		Y 280		
	This Regulation is not met as evidenced by Based on interview and record review on 3/2 the facility failed to ensure kitchen consultativere provided for 4 of the last 4 quarters.  Severity: 2 Scope: 3	24/09,			
Y 527 SS=D	449.260(1)(b) Activities for Residents		Y 527		
	NAC 449.260 1. The caregivers employed by a residential facility shall: (b) Provide group activities that provide mer and physical stimulation and develop creativiskills and interests.	ntal			
	This Regulation is not met as evidenced by Based on observation, interview and record review on 3/24/09, the facility failed to provid variety of group activities based on the intervof the residents interviewed (Sittercise five of week at 9:00 AM, Bingo five days a week at PM, and movies three days a week at 6:00 In	de a ests lays a 1:00			
Y 536 SS=D	Severity: 2 Scope: 1 449.260(4)(a) Activities for Residents		Y 536		

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failed to ensure 1 of 7 medication technicians met the requirement for medication administration training (Employee #2) and failed to ensure 3 of 15 residents had medication administration agreements (Residents #1, #5 and #11).

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O			PLE CONSTRUCTION	(X3) DATE SU COMPLET	
				A. BUILDING B. WING			
		NVS3184AGC	070557.400			03/3	0/2009
NAME OF PF	ROVIDER OR SUPPLIER		5975 W TW	RESS, CITY, STA	ATE, ZIP CODE		
MARGAR	ET ROSE RED ROCK AS	SSTD LIV		S, NV 89103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
Y 876	Continued From page	e 8		Y 876			
	Severity: 2 Scope: 1						
Y 878 SS=D	449.2742(6)(a)(1) Me	edication / Change orde	r	Y 878			
	the physician. If a ph the amount or times in administered to a res	ation prescribed by a Iministered as prescribe hysician orders a chang medication is to be sident: ponsible for assisting in medication shall:	e in				
	Based on record revithe facility would be uneeded (PRN) medic 15 residents because were not available in #12 and #13).	ot met as evidenced by: ew and interview on 3/2 unable to administer as cations as prescribed for their PRN medications the facility (Resident #	24/09, r 3 of				
	Severity: 2 Scope:	1					
Y 896 SS=D	449.2744(1)(b)(2) Me	edication / MAR		Y 896			
	provides assistance t	of a residential facility the to residents in the dication shall maintain:	nat				

PRINTED: 07/09/2009

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NVS3184AGC

NAME OF PROVIDER OR SUPPLIER

MARGARET ROSE RED ROCK ASSTD LIV

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING D3/30/2009

STREET ADDRESS, CITY, STATE, ZIP CODE

5975 W TWAIN AVE LAS VEGAS, NV 89103

ARGARET ROSE RED ROCK ASSTD LIV		5975 W TWAIN AVE LAS VEGAS, NV 89103				
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 896	Continued From page 9		Y 896			
	<ul><li>(b) A record of the medication administered each resident. The record must include:</li><li>(2) The date and time that the medicatio administered.</li></ul>					
	This Regulation is not met as evidenced by Based on interview and record review from 3/24/09 to 3/30/09, the facility failed to ensur caregivers documented on the medication administration records (MARs) the administr of narcotic medications to 2 of 16 residents(Residents #1 and #14)	re				
	Severity: 2 Scope: 1					
Y 908 SS=D	449.2746(2)(a)-(f) PRN Medication Record		Y 908			
	NAC 449.2746  2. A caregiver who administers medication to a resident as needed shall record the following information concerning the administration of the medication:  (a) The reason for the administration.  (b) The date and time of the administration;  (c) The dose administered;  (d) The results of the administration of the medication;  (e) The initials of the caregiver; and  (f) Instructions for administering the medicat the resident that reflect each current order of prescription of the resident 's physician.	I				

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review on 3/24/09, the facility failed to keep medications belonging to 27 of 27 residents in their original containers (Resident #3, #4, #8, #9, #13 plus 22 other residents not in the sample but scheduled to receive medications at noon or 2:00

PM on 3/24/09).

Severity: 2 Scope: 3

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3184AGC 03/30/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5975 W TWAIN AVE MARGARET ROSE RED ROCK ASSTD LIV LAS VEGAS, NV 89103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y1010 Continued From page 11 Y1010 Y1010 Y1010 449.2764(1) MI Training SS=F NAC 449.2764 1. A person who provides care for a resident of a residential facility for persons with mental illnesses shall, within 60 days after he becomes employed at the facility, attend not less than 8 hours of training concerning care for residents who are suffering from mental illnesses. This Regulation is not met as evidenced by: Based on record review on 3/24/09, the facility failed to ensure that a minimum of 4 hours of training related to the care of elderly and disabled residents was received within 60 days of hire by 2 of 2 caregivers hired within the last 12 months (Employee #4 and #5). Severity: 2 Scope: 3